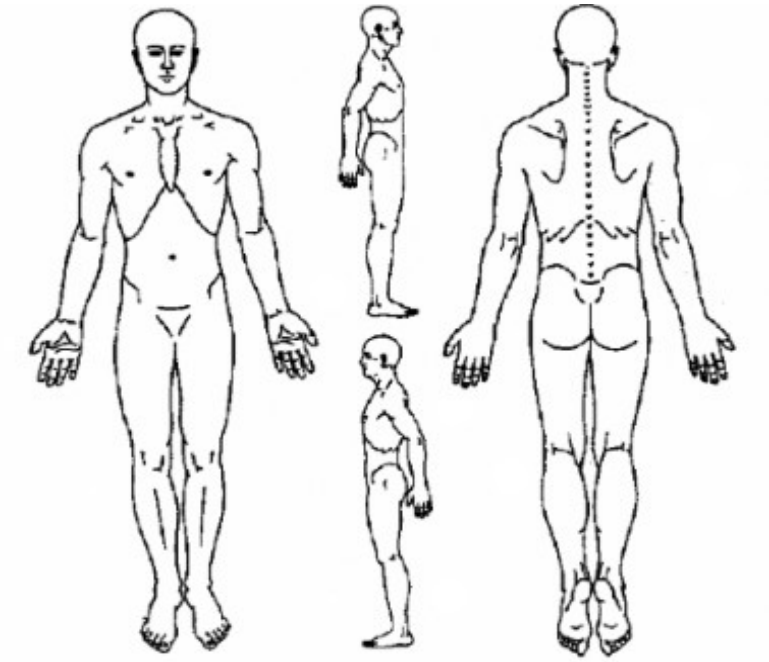
PAIN DIAGRAM

PATIENT NAME_____ **DATE**_____

1. Is this a new problem? _____ 2. Was this an injury? _____
3. When did your symptoms start?_____
4. How did your symptoms begin?_____
5. Using the appropriate symbol, mark the area of injury or discomfort on the chart below:(send to **pmcpcmh@gmail.com**)

o Numbness or Pins and Needles
x Aching
Stabbing



6. How often do you experience symptoms (Circle one):

Constantly 76-100% of the day
Frequently 51-75% of the day
Occasionally 26-50% of the day
Intermittently 0-25% of the day

7. My pain is:

None Unbearable

8 My pain is worse:

9. What describes the nature of your symptoms (Circle all that apply):

Sharp ☐ Shooting ☐ Numbness ☐
Dull Ache ☐ Burning ☐ Tingling ☐

10. How are your symptoms changing (Circle one):

Getting Better Not Changing Getting Worse

11. During the past 4 weeks:

a. Indicate the intensity of your symptoms (Circle One):

0	1	2	3	4	5	6	7	8	9	10

b. How much has the pain interfered with your normal work (include both work outside the home and housework):

(Circle One) Not at All A Little Bit Moderately Quite a Bit Extremely

12. During the past 4 weeks how much of the time has your condition interfered with your social activities (Circle One):

Not at All A Little Bit Moderately Quite a Bit All of the Time

13. Who have your seen for your symptoms (Circle all that apply):

No One ☐ Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other_____

a. What treatment did you receive and when?_____
b. What tests have you had for your symptoms and when were they performed?

X Rays *Date*_____ CT Scan *Date*_____
MRI *Date*_____ Other *Date*_____

14. What makes the problem worse? _____
15. What makes the problem better? _____
16. Have you taken any medicines for the problem? Please list: _____
17. Are there associated symptoms? Swelling ☐ Numbness ☐
Weakness ☐ Fever ☐ Other:_____

14. Describe your symptoms

_____

_____

REVIEWED BY: M. MACKENZIE, MD _____ N. HOFBERG _____ CLINICAL ASSISTANT_____